

10336

185-

Reg. Dist. No.

10363

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Harford</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>near Ham de Grace, Md.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
c. LENGTH OF STAY IN 1b <i>77 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>near Ham de Grace, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>none</i>		d. STREET ADDRESS <i>Old Bay Farm</i>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>Harvey</i> Last <i>Baker</i>		4. DATE OF DEATH Month <i>10/24/56</i> Day <i>19</i> Year <i>19</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/15/1879</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR: Months <i>77</i> Days <i>77</i> Hours <i>77</i> Min. <i>77</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Painter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
11. BIRTHPLACE (State or foreign country) <i>Harford County</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harvey Baker</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Maurin Baker</i> Address <i>609 Bay Shore Rd. 15 - Balto. 20, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>430.1</i> DUE TO <i>Arteriosclerotic Cardiovascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Disease</i> (c) <i>Coronary Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10/23</i> , 19 <i>56</i> to <i>10/24</i> , 19 <i>56</i> that I last saw the deceased alive on <i>10/23/56</i> , and that death occurred at <i>10:00</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles J. Foley</i> M.D.		ADDRESS (Street, city or town, state) <i>Ham de Grace, Md.</i> DATE SIGNED <i>10/23/56</i>	
PHYSICIAN'S NAME (Type) <i>CHARLES J. FOLEY</i>		<i>HAUDE DE GRACE, Md.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>10/27/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Smiths Chapel</i>	22d. LOCATION (City, town, or county) (State) <i>Churchville, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Longman & Son</i> ADDRESS <i>Ham de Grace, Md.</i>		24a. REC'D BY REGISTRAR <i>Oct 26 56</i>	24b. REGISTRAR'S SIGNATURE <i>G. L. Lewis M.D.</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

John A. Howard

10/22/91 10/22/91

John W. D. D.

1956-28-100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G205 10-17-56 et

CERTIFICATE OF DEATH

10364

10337

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY Cook	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b 6 months	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chicago		51x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen PG Md		d. STREET ADDRESS North Kenmore	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jesse Earl Belville		4. DATE OF DEATH Month Day Year October 10 19 56	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28 1897
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Carpentry	
11. BIRTHPLACE (State or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William E Belville		14. MOTHER'S MAIDEN NAME Marget Bodkin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 347-01-2096	
17. INFORMANT son-in-law (Daniel L Cunningham)		Address 307 H Augusta St Aberdeen, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DOB (1:18AM) 19 to 19, that I last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE [Signature] M.D. US Army Hospital Aberdeen PG Md 10 Oct 56 PHYSICIAN'S NAME (Type) HEINO AIARI, Capt MC			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/11/56	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) Macomb Illinois	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Garring		ADDRESS Address Maryland	
24a. REC'D BY REGISTRAR DATE Oct 12-56		24b. REGISTRAR'S SIGNATURE Melie R. Perry	

RECEIVED

OCT 15 1956

BUREAU V. S.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10365 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10338

CERTIFICATE OF DEATH

Reg. Dist. No.

181

Item 3: G205 1031

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Aberdeen				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Aberdeen			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Sadie Middle Sarah Last Black				4. DATE OF DEATH Month October Day 15 Year 19 56			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7 August 1881	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Barney Butler				14. MOTHER'S MAIDEN NAME Julia Grinage			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mrs. Oscar Kelly, Box 14, Aberdeen, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolism - 141X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma DUE TO (c) Carcinoma of tongue.							INTERVAL BETWEEN ONSET AND DEATH 1 hour 6 hrs. 2 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 55 , to Oct 15 , 19 56 , that I last saw the deceased alive on Oct 15 , 19 56 , and that death occurred at 130 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank Wolbert MD M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Home as given his Oct 16, 1956			
PHYSICIAN'S NAME (Type) Frank Wolbert, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/19/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Aberdeen, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring				ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR Oct 16 - 56	
				24b. REGISTRAR'S SIGNATURE Nellie R Perry			

CERTIFICATE OF DEATH

Name of Deceased Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England
Cause of Death Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England

Name of Deceased Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England
Cause of Death Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England

Name of Deceased Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England
Cause of Death Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England

Name of Deceased Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England
Cause of Death Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England

Name of Deceased Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England
Cause of Death Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England

Name of Deceased Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England
Cause of Death Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England

Name of Deceased Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England
Cause of Death Rural, Afternoon		Sex Male	Age 19	Date of Birth 1935	Place of Birth England

BUREAU V. 5

OCT 18 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

185

10346

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> <i>Maryland</i> <i>MARYLAND</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harold Chase</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harold Chase, Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>none</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Everista</i> Middle <i>Buechi</i> Last <i>Buechi</i>		4. DATE OF DEATH Month <i>10</i> Day <i>24</i> Year <i>1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/11/1889</i>
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR: Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Blind Shoe Maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	
11. BIRTHPLACE (State or foreign country) <i>Italy</i>		12. CITIZEN OF WHAT COUNTRY? <i>Italy</i>	
13. FATHER'S NAME <i>George Buechi</i>		14. MOTHER'S MAIDEN NAME <i>Familia Trincia</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Alfred Buechi</i>		Address <i>115 Market St. Harold Chase, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Constrictive Heart Failure</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cancer of the lung.</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <i>8 month</i> <i>3-4 month</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan. 3</i> , 19 <i>56</i> , to <i>Oct. 24</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Oct. 24</i> , 19 <i>56</i> , and that death occurred at <i>9:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Cunther D. Hirsch</i> M.D.		ADDRESS (Street, city or town, state) <i>HAVRE DE GRACE</i> DATE SIGNED <i>10-25-56</i>	
PHYSICIAN'S NAME (Type) <i>CUNTER D. HIRSCH</i>		ADDRESS <i>HAVRE DE GRACE, MD.</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>10/27/56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion</i>	22d. LOCATION (City, town, or county) (State) <i>Harold Chase Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pennington & Son, Harold Chase, Md.</i>		24a. REC'D BY REGISTRAR <i>Oct. 26-56</i>	24b. REGISTRAR'S SIGNATURE <i>A. L. Lewis m.d.</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 29 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)						
a. COUNTY Harford					a. STATE MD b. COUNTY Harford						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air						
c. LENGTH OF STAY IN 1b Life					d. STREET ADDRESS						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH						
First 180 C. Middle Lee Last BULL					Month October Day 1 Year 1956						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 25/1921		9. AGE (In years last birthday) 34 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed		10b. KIND OF BUSINESS OR INDUSTRY Shirt Presser		11. BIRTHPLACE (State or foreign country) Bel Air Md		12. CITIZEN OF WHAT COUNTRY? US		IF UNDER 1 YEAR Months Days Hours Min.			
13. FATHER'S NAME Milton J Bull					14. MOTHER'S MAIDEN NAME Anna M Elliott						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes					16. SOCIAL SECURITY NO. 212-20-7820					17. INFORMANT Mrs Julia B Bull Address 136 Main St Bel Air Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary sclerosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED White <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE R S Fisher					M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED 10/1/56						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 3/56		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens			22d. LOCATION (City, town, or county) (State) Bel Air Md				
23. FUNERAL DIRECTOR'S SIGNATURE Joseph J. Foster					ADDRESS Bel Air Md		24a. REC'D BY REGISTRAR 10-2-56		24b. REGISTRAR'S SIGNATURE Priscilla Forward		

MEDICAL CERTIFICATION

STATE OF NEW YORK
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

HARTFORD

HARTFORD

HARTFORD

Boi Air

26

October

BILL

White

Male

11-11-1956

11-11-1956

11-11-1956

11-11-1956

BUREAU V. 8

OCT 5 1956

RECEIVED

Russell S. Fisher, M.D.

11-11-1956

11-11-1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10341

10366

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rd</u>		c. LENGTH OF STAY IN b <u>3 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rd</u>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>V.</u> Last <u>Bull</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>1</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 8-1873</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Maid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bel Air Rd</u>	
11. BIRTHPLACE (State or foreign country) <u>US</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Jacob E Bull</u>		14. MOTHER'S MAIDEN NAME <u>Mary T Sunderland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-30-6385</u>	
		17. INFORMANT <u>Mrs Fred Scotten</u> Address <u>Bel Air Rd 3 Box 124</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) <u>5-10 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>1 Oct</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>29 Sep</u> , 19 <u>56</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles Richardson</u> M.D.		ADDRESS (Street, city or town, state) <u>1265 Main, Bel Air, Md</u>	
DATE SIGNED <u>20-1-56</u>			
PHYSICIAN'S NAME (Type) <u>Charles Richardson Jr</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Oct 4/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ROCKSPRING</u>		22d. LOCATION (City, town, or county) (State) <u>FORREST HILL Hartford</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR DATE <u>10-2-56</u>	
		24b. REGISTRAR'S SIGNATURE <u>Phyllis Lowwood</u>	

6-11-84

29.11.15 6.30 PM

25 9/4/85

5. Smoking -

15.8

1896

[Faint handwritten text at the bottom of the page]

7-2-64-312

1992

1845

BUREAU V.

OCT 5 1956

RECEIVED
OCT 5 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10348

CERTIFICATE OF DEATH

10342

Reg. Dist. No.

185-

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>		c. LENGTH OF STAY IN 1b <u>10 hrs. 10 Min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVERDE GRACE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>558 BOURBON ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>(Ladic) SARAH ELIZABETH Charshoe</u> First Middle Last				4. DATE OF DEATH <u>October 7 1956</u> Month Day Year			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1882 SEPT. 29 1956</u>	9. AGE (In years lost birthday) <u>74</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM CLARK</u>				14. MOTHER'S MAIDEN NAME <u>MARY CLOAK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>RICHARD CLARK CHARSHOE HAVERDE GRACE MD</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>433.0</u> DUE TO <u>Coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>saddle block</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>10 hours</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. a. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 7</u> , 19 <u>56</u> , to <u>Oct 7</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Oct 7</u> , 19 <u>56</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. J. Simon</u>		ADDRESS (Street, city or town, state) <u>HAVERDE GRACE, MD</u> DATE SIGNED <u>Oct 10-7-56</u>					
PHYSICIAN'S NAME (Type) <u>E. J. SIMON</u>		M.D. <u>HAVERDE GRACE, MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-10-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>HAVERDE GRACE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>HAVERDE GRACE MD.</u>				24a. REC'D BY REGISTRAR <u>DATE 10-10-56</u>		24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis m.d.</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford de Grace</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. (If Institution: Residence before admission) ✓ a. STATE <u>md</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3101-4</u> d. STREET ADDRESS <u>2249 E. Biddle St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Council</u> Middle Last		4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1956</u>		5. SEX <u>Male</u>			
6. COLOR OR RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 1911</u>			
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Edmond Council</u>			
14. MOTHER'S MAIDEN NAME <u>Alice Rich</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO. <u>242-09-254</u>		17. INFORMANT Address <u>Ruth Council 2249 E. Biddle St.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO <u>819X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto-accident auto-object type</u>					
20c. TIME OF INJURY Month, Day, Year <u>4:30</u> a. m. <u>10/1</u> <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US Route 1</u>			
20f. (City or town) <u>Rowlingford</u>		20g. (County) <u>Hartford</u>		20h. (State) <u>md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <u>Gerald C Palmer-Baltimore</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <u>Hartford</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct. 6, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>			
22d. LOCATION (City, town, or county) <u>A. A. County</u>		22e. (State) <u>md.</u>		24a. REC'D BY REGISTRAR			
24b. REGISTRAR'S SIGNATURE <u>P. H. Williams</u>		24c. ADDRESS <u>701-03 N. Bond St</u>		24d. DATE <u>4 1956</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 4 1956

RECEIVED

10350 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH a. COUNTY <u>Aberdeen</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Hartford</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. LENGTH OF STAY IN 1b <u>5 mo</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Edmund Street Extended</u>			d. STREET ADDRESS <u>Edmund St Extended</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Lewis</u> Middle <u>Edward</u> Last <u>Yeruison</u>			4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>1956</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7th 1956</u>		9. AGE (In years last birthday) <u>5</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Lewis E. Yeruison Sr.</u>			14. MOTHER'S MAIDEN NAME <u>E. G. Gypree</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Same as (13)</u> Address <u>Aberdeen Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . <u>Gerald C Palmer MD</u>					
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <u>B. A. T. in Md. 10/28/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/31/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union W. E. Cemetery</u>		22d. LOCATION (City, town, or county) <u>Aberdeen Md.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Sarring</u>		ADDRESS <u>Aberdeen Md.</u>		24a. REC'D BY REGISTRAR <u>Oct 30-56</u>	24b. REGISTRAR'S SIGNATURE <u>Nellie K. Perry</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

Items 14, 17:
G206 11-7-56L

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10345

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

187

1. PLACE OF DEATH a. COUNTY 10367 HARTFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE District of Columbia COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Churchville		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Washington 914 Delafield Place, N.W.	
3. NAME OF DECEASED (Type or print) First Helen Middle Mary Last English		4. DATE OF DEATH Month Found Day October Year 23 19 56	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15, 1922
9. AGE (In years last birthday) 34 yrs.		10. IF UNDER 1 YEAR Months 47 Days x Hours 3 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Philadelphia, Pa		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Burke		14. MOTHER'S MAIDEN NAME Mary E. Ottmer/ Ottmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT JOHN A. BURKE, 6613 N. Bouvier st. Grafton D. English, Philadelphia, Pa.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fatty infiltration of liver 581.1 DUE TO Chronic alcoholism Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Russell S. Fisher		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		DATE SIGNED 10/23/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10-26=56	
22c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		22d. LOCATION (City, town, or county) (State) Philadelphia, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc.,		ADDRESS 1217 S. Paul Street	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Russell S. Fisher	

OCT 29 1956

Division of Colonies

Washington

111 Webster Place, N. W.

English

Mary

Helen

BUREAU V. S.

OCT 31 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10346

10351

CERTIFICATE OF DEATH

Reg. Dist. No.

188-

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MOULIE Middle DAY Last ESTES				4. DATE OF DEATH Month OCTOBER Day 19 Year 1956			
5. SEX FEMALE		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 5th 1892	
9. AGE (In years last birthday) 64 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSW		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME THOMAS DAY			
14. MOTHER'S MAIDEN NAME ELIZABETH HARRISON				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give year or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT Yajid W. Estes, Box 84H Bel Air Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular and DUE TO Hypertensive Cardiovascular Disease (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis with bronchopneumonia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from Oct. 11th., 1956 to Oct. 19th., 1956 , that I last saw the deceased alive on Oct. 18th., 1956 , and that death occurred at 5:45 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward C. Loo M.D. 211 N. Union Ave.				DATE SIGNED Oct 19th. 1956			
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.				ADDRESS (Street, city or town, state) Haure de Grace, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/56		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Garing ADDRESS Aberdeen, Md.				24a. REC'D BY REGISTRAR Oct. 23-56		24b. REGISTRAR'S SIGNATURE G. L. Lewis	

BUREAU V. 31

OCT 24 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10347

10352

CERTIFICATE OF DEATH

Reg. Dist. No.

185

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>38 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>424 N. Stokes</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>-</u> Last <u>Kilbuck</u>				4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/26/1883</u>	9. AGE (In years last birthday) <u>73</u> yrs.	10. IF UNDER 1 YEAR Months <u>8</u> Days <u>18</u> Hours <u>19</u> Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Remuneration G.P.D.</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ramuel F. Kilbuck</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Harper</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Mrs. Lily W. Kilbuck</u>		Address <u>424 N. Stokes Harford</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u> DUE TO (c) <u>arteriosclerosis - Jacksonian Epilepsy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 day -</u> <u>2 years -</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 1955, to <u>Oct 11</u> , 1956, that I last saw the deceased alive on <u>Oct 11</u> , 1956, and that death occurred at <u>7:30 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank Wolbert M.D.</u> M.D.				ADDRESS (Street, city or town, state) <u>Harford Grace Md.</u> DATE SIGNED <u>Oct 13, 1956</u>			
PHYSICIAN'S NAME (Type) <u>FRANK WOLBERT M.D.</u>				<u>HARFORD GRACE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/14/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Harford Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin P. M. Harford</u>				ADDRESS <u>Harford</u>		24a. REC'D BY REGISTRAR DATE <u>10-14-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>G. L. Lewis M.D.</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>		3. AGE <i>45</i>	
4. PLACE OF BIRTH <i>NEW YORK</i>		5. DATE OF BIRTH <i>1911</i>		6. PLACE OF DEATH <i>BALTIMORE</i>	
7. OCCUPATION <i>CLERK</i>		8. CAUSE OF DEATH <i>HEART DISEASE</i>		9. MANNER OF DEATH <i>NATURAL</i>	
10. SIGNATURE OF PHYSICIAN <i>[Signature]</i>		11. SIGNATURE OF REGISTRAR <i>[Signature]</i>		12. SIGNATURE OF WITNESS <i>[Signature]</i>	
13. DATE OF DEATH <i>OCT 15 1956</i>		14. TIME OF DEATH <i>10:30 AM</i>		15. PLACE OF INTERMENT <i>ST. MARY'S CATHEDRAL</i>	
16. NAME OF FUNERAL HOME <i>JOHN J. SMITH & SONS</i>		17. ADDRESS OF FUNERAL HOME <i>1234 E. BALTIMORE</i>		18. TELEPHONE OF FUNERAL HOME <i>555-1234</i>	
19. NAME OF NEXT OF KIN <i>MRS. J. J. SMITH</i>		20. ADDRESS OF NEXT OF KIN <i>456 N. BALTIMORE</i>		21. TELEPHONE OF NEXT OF KIN <i>555-5678</i>	
22. NAME OF CLERGYMAN <i>REVEREND J. J. SMITH</i>		23. ADDRESS OF CLERGYMAN <i>789 S. BALTIMORE</i>		24. TELEPHONE OF CLERGYMAN <i>555-9012</i>	
25. NAME OF MINISTER <i>REVEREND J. J. SMITH</i>		26. ADDRESS OF MINISTER <i>1011 W. BALTIMORE</i>		27. TELEPHONE OF MINISTER <i>555-3456</i>	
28. NAME OF CHURCH <i>ST. MARY'S CATHEDRAL</i>		29. ADDRESS OF CHURCH <i>1234 E. BALTIMORE</i>		30. TELEPHONE OF CHURCH <i>555-7890</i>	
31. NAME OF RABBI <i>REVEREND J. J. SMITH</i>		32. ADDRESS OF RABBI <i>5678 N. BALTIMORE</i>		33. TELEPHONE OF RABBI <i>555-2345</i>	
34. NAME OF SYNAGOGUE <i>ST. MARY'S CATHEDRAL</i>		35. ADDRESS OF SYNAGOGUE <i>9012 S. BALTIMORE</i>		36. TELEPHONE OF SYNAGOGUE <i>555-6789</i>	
37. NAME OF MOSQUE <i>REVEREND J. J. SMITH</i>		38. ADDRESS OF MOSQUE <i>3456 W. BALTIMORE</i>		39. TELEPHONE OF MOSQUE <i>555-0123</i>	
40. NAME OF TEMPLE <i>REVEREND J. J. SMITH</i>		41. ADDRESS OF TEMPLE <i>7890 E. BALTIMORE</i>		42. TELEPHONE OF TEMPLE <i>555-4567</i>	

BUREAU V. S.

OCT 16 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10348

10368

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEFORD			c. LENGTH OF STAY IN 1b 39 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHITEFORD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last NELLIE MCKINLEY GLASGOW				4. DATE OF DEATH Month Day Year OCT. 18, 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 2, 1897		9. AGE (In years last birthday) 59 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) YORK CO., PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME S. A. MCKINLEY				14. MOTHER'S MAIDEN NAME PHOEBE GRIMES			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT Address WARREN C. GLASGOW, WHITEFORD, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 602x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Renal Calculi DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarction - Hypertensive C-V Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1942 , to OCT 18, 1956 , that I last saw the deceased alive on OCT 18, 1956 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph A. Hunt M.D.				ADDRESS (Street, city or town, state) Delta, Pa.		DATE SIGNED 10/19/56	
PHYSICIAN'S NAME (Type) Josiah A Hunt, M.D.				Delta, Pa.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-21-56		22c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE		22d. LOCATION (City, town, or county) (State) DELTA, PA.	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harbison				ADDRESS Delta, Pa.		24a. REC'D BY REGISTRAR DATE 10-21-56	
				24b. REGISTRAR'S SIGNATURE Priscilla Lowood			

BUREAU V. S.

OCT 23 1956

RECEIVED

10353

CERTIFICATE OF DEATH

Reg. Dist. No.

185-

1. PLACE OF DEATH a. COUNTY <u>Harford Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Grace, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>none</u>				d. STREET ADDRESS <u>618 Water</u>			
3. NAME OF DECEASED (Type or print) <u>Male</u> <u>Charles</u> <u>Hopkins</u> First Middle Last				4. DATE OF DEATH <u>10/20/56</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 18 1890</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Grace, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sherman Freyde</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Stone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mrs. Wm. Blomfield</u> Address <u>618 Water St., Harford Grace, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerosis Cardiac Vascular</u> <u>260X</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decomposition</u> DUE TO <u>Cadaveria</u> (c) <u>Cadaveria</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1, 1954</u> , to <u>Oct 20, 1956</u> that I last saw the deceased alive on <u>Oct 20, 1956</u> , and that death occurred at <u>7 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D.				ADDRESS (Street, city or town, state) <u>Harford Grace, Md.</u> DATE SIGNED <u>Oct 20 1956</u>			
PHYSICIAN'S NAME (Type) <u>Charles J. Foley</u>				ADDRESS <u>Harford Grace, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Benjamin J. M. Harford Grace, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>Oct. 22-56</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. Lewis M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

956T 48 100

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 181

10369

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen				c. LENGTH OF STAY IN 1b 10 Min			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Hospital Aberdeen Proving Ground				e. STREET ADDRESS Route #2 Earlton Road			
3. NAME OF DECEASED (Type or print) Cynthia Lynn Hughes				4. DATE OF DEATH October 22 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 22, 1956	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rodney Dale Hughes				14. MOTHER'S MAIDEN NAME Dellray Zelpia Hamm			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Father Address as in 2 above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anoxia 761.5 DUE TO Cord around neck three times Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO Premature labor (c)							INTERVAL BETWEEN ONSET AND DEATH 10 Min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from October 22, 1956 , to October 22, 1956 , that I last saw the deceased alive on October 22, 1956 , and that death occurred at 12:55p. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert D Hume Jr. M.D.				ADDRESS (Street, city or town, state) US Army Hospital Aberdeen Proving Ground, Maryland			
DATE SIGNED October 22, 1956							
PHYSICIAN'S NAME (Type) ROBERT D HUME JR, Lt Col, MC							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 24 1956		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		22d. LOCATION (City, town, or county) (State) Bel Air Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Lanning ADDRESS Aberdeen Md				24a. REC'D BY REGISTRAR Oct 23 56		24b. REGISTRAR'S SIGNATURE Nellie R Perry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU V. S.

9561 40 100

RECEIVED

10370

CERTIFICATE OF DEATH

Reg. Dist. No.

180

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abingdon	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Virginia Middle Pauline Last Jarusek		4. DATE OF DEATH Month Oct. Day 27 Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1926
9. AGE (In years last birthday) 30 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joe C. Lovelace		14. MOTHER'S MAIDEN NAME Lula Billings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 231-24-1715	
17. INFORMANT Elmer C. Jarusek		Address Abingdon, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia (unknown origin) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with terminal hemorrhagic Pneumonia DUE TO (c) 4-5 yrs		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 27, 1956 , to Oct 27, 1956 , that I last saw the deceased alive on Oct 27, 1956 , and that death occurred at 11 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Jed O Hodous		ADDRESS (Street, city or town, state) Edgewood Md	
PHYSICIAN'S NAME (Type) F. O. Hodous		DATE SIGNED 10-30-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 31, 1956	
22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or county) (State) Abingdon, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McCombs & Son		ADDRESS Abingdon, Md.	
24a. REC'D BY REGISTRAR Oct 31, 1956		24b. REGISTRAR'S SIGNATURE Norma S. Moore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NOV 2 1956

RECEIVED

10371

CERTIFICATE OF DEATH

Reg. Dist. No.

180

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONG BAR HARBOR		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARBUTUS 27	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION E. BAKER AVE		d. STREET ADDRESS 1232 GREYSTONE RD	
3. NAME OF DECEASED (Type or print) First EDITH Middle LEE Last JOHNSON		4. DATE OF DEATH Month OCTOBER Day 28 Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 3, 1866
9. AGE (In years last birthday) yrs. 90		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM ISLER		14. MOTHER'S MAIDEN NAME EUGENIA PATTERSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS HELEN E. AGUIAR, ARBUTUS, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR ACCIDENT 391X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ARTERIO SCLEROSIS (b) ARTERIO SCLEROSIS DUE TO (c) ARTERIO SCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 1 WK. MANY YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) FRACTURE RIGHT HIP MARCH 8, 1956		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) SHIPPED AND FELL IN KITCHEN		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 1:00 p. m. MAR 8 1956		20d. INJURY OCCURRED While of work <input checked="" type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME		20f. (City or town) (County) (State) ARBUTUS, BALTIMORE, Md.	
21. I certify that I attended the deceased from OCT 22, 1956 , to OCT 28, 1956 , that I last saw the deceased alive on OCT 27, 1956 , and that death occurred at 1:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip W. Heuman M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 307 HICKORY, BEL AIR, Md OCT 28, 1956	
PHYSICIAN'S NAME (Type) PHILIP W. HEUMAN, M.D., Deputy County Coroner			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-1-56	22c. NAME OF CEMETERY OR CREMATORY MASONIC	22d. LOCATION (City, town, or county) (State) MIDDLEWAY, W. VA.
23. FUNERAL DIRECTOR'S SIGNATURE M. T. Strider, Charlestown, W. Va.		24a. REC'D BY REGISTRAR OCT 30 1956	
		24b. REGISTRAR'S SIGNATURE Philip W. Heuman	

MEDICAL CERTIFICATION

03

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED: *John Doe*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF DEATH: *October 31, 1956*

5. PLACE OF DEATH: *Home*

6. CAUSE OF DEATH: *Heart Disease*

7. MANNER OF DEATH: *Natural*

8. SIGNATURE OF PHYSICIAN: *[Signature]*

9. SIGNATURE OF REGISTRAR: *[Signature]*

10. DATE OF REGISTRATION: *October 31, 1956*

11. PLACE OF REGISTRATION: *Baltimore*

12. NAME OF REGISTRAR: *[Name]*

13. ADDRESS OF REGISTRAR: *[Address]*

14. TELEPHONE OF REGISTRAR: *[Phone Number]*

15. NAME OF DECEASED: *John Doe*

16. SEX: *Male*

17. AGE: *45*

18. DATE OF DEATH: *October 31, 1956*

19. PLACE OF DEATH: *Home*

20. CAUSE OF DEATH: *Heart Disease*

21. MANNER OF DEATH: *Natural*

22. SIGNATURE OF PHYSICIAN: *[Signature]*

23. SIGNATURE OF REGISTRAR: *[Signature]*

24. DATE OF REGISTRATION: *October 31, 1956*

25. PLACE OF REGISTRATION: *Baltimore*

26. NAME OF REGISTRAR: *[Name]*

27. ADDRESS OF REGISTRAR: *[Address]*

28. TELEPHONE OF REGISTRAR: *[Phone Number]*

BUREAU V. S.

OCT 31 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10354

Reg. Dist. No. 182

10372

1. PLACE OF DEATH a. COUNTY <u>Harris</u> ✓ MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penn</u> b. COUNTY <u>Phila</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RDI</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Richard J. Kinderman</u>		4. DATE OF DEATH <u>Oct 11 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 19-1929</u>
9. AGE (In years last birthday) <u>26</u> yrs.		IF UNDER 1 YEAR: Months <u>11</u> Days <u>11</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank Teller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bank</u>	
11. BIRTHPLACE (State or foreign country) <u>Philadelphia Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Walter J Kinderman</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Scaylon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <input checked="" type="checkbox"/> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>4-2-100000000</u>	
17. INFORMANT <u>Walter J Kinderman</u> Address <u>109 Nippon St Philadelphia, Pa (19)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of abdomen</u> DUE TO (b) <u>976X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>976X</u> DUE TO (c) <u>976X</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with .22 rifle</u>	
20c. TIME OF INJURY Month, Day, Year <u>Oct 11 1956</u> Hour <u>10-11</u> a. m. <u>10-11</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Church yard</u>		20f. (City or town) <u>Bel Air</u> (County) <u>Harris</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <u>Harvey E</u>		DATE SIGNED <u>10-11-56</u>	
22a. BURIAL: CREMATION: REMOVAL (Specify) <u>Oct 13/56</u>		22b. DATE THEREOF <u>Oct 13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Thiladelphia</u>		22d. LOCATION (City, town, or county) <u>Thiladelphia Pa</u> (State) <u>Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. [unclear]</u> ADDRESS <u>Bel Air Md</u>		24a. REC'D BY REGISTRAR <u>Patricia [unclear]</u> 24b. REGISTRAR'S SIGNATURE <u>Patricia [unclear]</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: *Richard J. ...*
 SEX: *M*
 AGE: *25*
 DATE OF BIRTH: *1931*
 PLACE OF BIRTH: *Philadelphia, Pa.*
 OCCUPATION: *Bank Teller*
 CAUSE OF DEATH: *Myocardial Infarction*
 MANNER OF DEATH: *Natural*
 SIGNATURE OF EXAMINER: *[Signature]*
 DATE: *Oct 15 1956*

BUREAU V. E.
 OCT 15 1956
RECEIVED

Oct 15 1956
10:15 AM

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10355

10373 CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>HARFORD</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>HARFORD</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL NORRISVILLE</u>	LENGTH OF STAY (in this place) <u>10 YRS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RURAL NORRISVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>REBECCA LOWE LUCKEY</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>10-1-1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>12-11-1874</u>
9. AGE last birthday <u>81</u> yrs.		10. DATE OF BIRTH Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co. Schools</u>	
11. BIRTHPLACE (State or foreign country) <u>HARFORD Co., MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LABAN LOWE</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET TAYLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS <u>Harry Samer, Harford Co. Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>260X Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
ANTECEDENT CAUSE(S) DUE TO (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic Myocarditis, Hypertension</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from June 1952, to Oct 1, 1955, that I last saw the deceased alive on Oct 1, 1956, and that death occurred at 3:30 P.M. from the causes and on the date stated above.			
SIGNATURE <u>Edward M. Hyslop</u> M.D.		DATE SIGNED <u>10/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. NAME OF CEMETERY OR CREMATORY <u>FRIENDS CEM.</u>	
DATE THEREOF <u>10-4-1956</u>		LOCATION (City, town, or county) <u>FARM GROVE, HARFORD CO., MD.</u>	
24. REC'D BY REGISTRAR <u>Priscilla Lowwood</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Graham</u>	
REGISTRAR'S SIGNATURE		ADDRESS <u>Stewartstown Pa</u>	
DATE <u>10-3-56</u>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

1

10354

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 FilmG205 10-29-56 et

103556

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesapeake</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>637 Parakee Court</u>		d. STREET ADDRESS <u>637 Parakee Court</u>	
3. NAME OF DECEASED (Type or print) First <u>Esther</u> Middle <u>D. James</u> Last <u>Mason</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>20</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2nd 1885</u>
9. AGE (In years last birthday) <u>70 1/2</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Phas. James</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Walter J. Mason - 637 Parakee Ct. Rd.</u>		Address <u>Chesapeake</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>3600</u> (b) <u>cerebral arteriosclerosis</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>Jan 11, 1956</u> to <u>Oct 20, 1956</u> , that I last saw the deceased alive on <u>Oct 20, 1956</u> , and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. J. Plunkitt, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>617 W. Belair Ave. Chesapeake, Md.</u>	
PHYSICIAN'S NAME (Type) <u> </u>		DATE SIGNED <u>10-21-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Oct 25-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Trenton New Jersey</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Sarring</u>		24a. REC'D BY REGISTRAR <u> </u>	
24b. REGISTRAR'S SIGNATURE <u>Nellie R. Pruy</u>		DATE <u>Oct 23, 56</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

<p>1. NAME OF DECEASED <i>John William Smith</i></p>		<p>2. SEX <i>Male</i></p>	
<p>3. AGE <i>45</i></p>		<p>4. DATE OF BIRTH <i>Jan 15 1910</i></p>	
<p>5. PLACE OF BIRTH <i>St. Louis, Mo.</i></p>		<p>6. OCCUPATION <i>Engineer</i></p>	
<p>7. MARITAL STATUS <i>Married</i></p>		<p>8. DATE OF MARRIAGE <i>June 10 1935</i></p>	
<p>9. NAME OF SPOUSE <i>Elizabeth Ann Smith</i></p>		<p>10. DATE OF DEATH <i>Oct 10 1956</i></p>	
<p>11. PLACE OF DEATH <i>Home</i></p>		<p>12. CAUSE OF DEATH <i>Heart Disease</i></p>	
<p>13. MEDICAL HISTORY <i>None</i></p>		<p>14. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i></p>	
<p>15. SIGNATURE OF REGISTRAR <i>John Doe</i></p>		<p>16. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i></p>	

BUREAU V. 8

OCT 24 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10357

10374

CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>HARFORD</u>		MARYLAND		STATE <u>WEST VA</u> COUNTY <u>RALIEGH</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>(RURAL) DARLINGTON</u>		LENGTH OF STAY (in this place) <u>7 MOS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BECKLEY</u>		<u>85X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>WILKERSON RD</u>				STREET ADDRESS (If rural give location) <u>RD #9 BEAVER, W. VA.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>BESSIE MIDDLETON MCCLURE</u>				(Month) (Day) (Year) <u>OCT 28 19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>OCT 20, 1884</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM SHIRKEY</u>				14. MOTHER'S MAIDEN NAME <u>ADDIE LONG</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>RUBY REED, DARLINGTON, Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic C-V Disease</u>						<u>6 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus</u>						<u>20 yrs</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 17, 1957</u> , to <u>Oct 29, 1956</u> , that I last saw the deceased alive on <u>Oct 29, 1956</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ralph Hake</u> M.D.				ADDRESS (Street, city, town, state) DATE SIGNED <u>Churchwood, Md Oct 29</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>Oct 29, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Beckley, W. Va</u>		LOCATION (City, town, or county) (State) <u>Beckley, W. Va</u>	
24. REC'D BY REGISTRAR <u>Oct 29, 1956</u>		REGISTRAR'S SIGNATURE <u>Bert B. Knight</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. D. Bailey</u>		ADDRESS <u>Darlington, W. Va</u>	

CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF OTHER

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

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BUREAU V. S.

OV 5 1956

RECEIVED

ENCLOSURE

THIS CERTIFICATE OF DEATH IS TO BE FILED IN THE OFFICE OF THE STATE DEPARTMENT OF HEALTH, ALBANY, N.Y. AND A COPY IS TO BE FURNISHED TO THE LOCAL HEALTH OFFICER, THE FUNERAL HOME, THE BURIAL SOCIETY, AND THE WITNESSES. IT IS THE DUTY OF THE REGISTRAR TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE LOCAL HEALTH OFFICER, THE FUNERAL HOME, THE BURIAL SOCIETY, AND THE WITNESSES. IT IS THE DUTY OF THE LOCAL HEALTH OFFICER TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR, THE FUNERAL HOME, THE BURIAL SOCIETY, AND THE WITNESSES. IT IS THE DUTY OF THE FUNERAL HOME TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR, THE LOCAL HEALTH OFFICER, THE BURIAL SOCIETY, AND THE WITNESSES. IT IS THE DUTY OF THE BURIAL SOCIETY TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR, THE LOCAL HEALTH OFFICER, THE FUNERAL HOME, AND THE WITNESSES. IT IS THE DUTY OF THE WITNESSES TO SIGN THIS CERTIFICATE OF DEATH AND TO FURNISH A COPY TO THE REGISTRAR, THE LOCAL HEALTH OFFICER, THE FUNERAL HOME, THE BURIAL SOCIETY, AND THE WITNESSES.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>8 MOS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>619 REVOLUTION ST.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>619 REVOLUTION ST</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JENNIE N. MOYE</u>		4. DATE OF DEATH Month Day Year <u>October 15 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 16, 1863</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM. A. J. GILLARD</u>		14. MOTHER'S MAIDEN NAME <u>Alice Ann SNYDER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MISS MARY E. MATRON, HAVRE DE GRACE MD</u>	
17. INFORMANT <u>MISS MARY E. MATRON, HAVRE DE GRACE MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Hypertension</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>Senility Cachexia</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 30, 1956</u> to <u>Oct 15, 1956</u> , that I last saw the deceased alive on <u>Oct 15, 1956</u> , and that death occurred at <u>6:40 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles J. Foley</u> M.D.		ADDRESS (Street, city or town, state) <u>Havre de Grace Md</u> DATE SIGNED <u>10-15-56</u>	
PHYSICIAN'S NAME (Type) <u>CHARLES J. FOLEY - HAVRE DE GRACE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	22b. DATE THEREOF <u>OCT 18 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SUNSET CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>RALEIGH CO. W. VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mott</u> ADDRESS <u>HAVRE DE GRACE MD</u>		24a. REC'D BY REGISTRAR <u>DATE 10-15-56</u> 24b. REGISTRAR'S SIGNATURE <u>A. L. Lewis m.c.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10. *Other comments:*

BUREAU V. S.

OCT 16 1956

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN lb <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) First <u>Howard M</u> Middle <u>Pecker</u> Last <u>Pecker</u>		4. DATE OF DEATH Month <u>October</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 14 - 1915</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Repair</u>	
11. BIRTHPLACE (State or foreign country) <u>Bell Air Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Frank Rice</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE PECKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs Lucille Pecker</u> Address <u>200 Archurst Bell Air Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E. Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E. Palmer MD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Harford County</u> 10-19-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Oct 22/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Joppa MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Bel Air</u> ADDRESS <u>MD</u>		24a. REC'D BY REGISTRAR <u>10-21-56</u>	24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowry</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

OCT 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10360

Reg. Dist. No. 182

10375

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last <u>Phoebe Leah Rainbow</u>				4. DATE OF DEATH Month Day Year <u>October-19</u> 195 <u>6</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 31, 1855</u>		9. AGE (In years last birthday) <u>100</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>				11. BIRTHPLACE (State or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Samuel Scott</u>						14. MOTHER'S MAIDEN NAME <u>Hannah?</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Mrs Warren Armos</u> <u>Forest Hill Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C V disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Gerald C Palmer</u>						M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED			
EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Harford</u>		<u>10/15/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)					
<u>Burial</u>				<u>Oct 17-56</u>		<u>Chestnut Grove ME</u>				<u>Rockers Harford Md</u>					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS						24a. REC'D BY REGISTRAR DATE				24b. REGISTRAR'S SIGNATURE					
<u>Martha K. K...</u>						<u>10-17-56</u>				<u>Bucilla Fenwood</u>					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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9th Grade Legal Research

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10361

Reg. Dist. No. 180

10376

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOPPA</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD SINGER Rd</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>JOPPA</u> d. STREET ADDRESS <u>RFD SINGER Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>DAVID</u> Middle <u>RUFF</u> Last <u>RUFF</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 10, 1898</u>
9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JESSE RUFF</u>		14. MOTHER'S MAIDEN NAME <u>MARTHA WATTERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>FLOYD RUFF (SON) JOPPA, MD.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (b) <u>Congestive Heart Failure</u> (c) <u>Arterio-Sclerotic Cardio-Vascular disease</u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PROSTATECTOMY 2 1/2 YRS AGO Johns Hopkins Hosp</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>unk</u> <u>unk</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>				
ACTUAL SIGNATURE <u>Philip W. Heuman</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>PHILIP W. HEUMAN M.D.</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Oct 7, 1956</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-10-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Harford Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. Frances A. HEMSLEY</u>		24b. REGISTRAR'S SIGNATURE <u>Norma L. Moore</u>		
24a. ADDRESS <u>578 W Biddle St</u>		24c. REC'D BY REGISTRAR <u>100</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. B.

OCT 9 1956

RECEIVED

10357

CERTIFICATE OF DEATH

Reg. Dist. No.

187

1. PLACE OF DEATH a. COUNTY <i>Baltimore Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Bel Air Conv. Home</i>				d. STREET ADDRESS <i>2207 Pelham Avenue</i>			
3. NAME OF DECEASED (Type or print) First <i>Mrs. Anna</i> Middle <i>M.</i> Last <i>Schmidt</i>				4. DATE OF DEATH Month <i>October</i> Day <i>22nd</i> Year <i>19 56</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 28, 1875</i>	9. AGE (In years last birthday) <i>80</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Edward Lohmann</i>			14. MOTHER'S MAIDEN NAME <i>?</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Mr. Robert Schmidt, 2207 Pelham Avenue.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>352x</i> DUE TO <i>templegia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-1</i> , 19 <i>55</i> <i>10-22</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>10-20</i> , 19 <i>56</i> , and that death occurred at <i>10A</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Gerald E Palmer</i> M.D.				ADDRESS (Street, city or town, state) <i>Bel Air, Md.</i>			
PHYSICIAN'S NAME (Type) <i>Gerald E Palmer M.D.</i>				DATE SIGNED <i>10-22-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/25/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Baltimore Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road #14</i>				24a. REC'D BY REGISTRAR <i>Oct. 23, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Lowery</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

10358

CERTIFICATE OF DEATH

Reg. Dist. No. 185-

1. PLACE OF DEATH a. COUNTY <i>Harford</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harvred Grace</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Bel Air</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Harford Memorial Hosp.</i>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <i>Pearl</i>		Middle <i>Evelyn</i>		Last <i>Smith</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>C</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-23-1901</i>	
9. AGE (In years last birthday) <i>55 yrs.</i>		IF UNDER 1 YEAR Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Servant</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Servant</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Addison Jones</i>				14. MOTHER'S MAIDEN NAME <i>Mary Bowser</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>215-28-0301</i>		17. INFORMANT <i>Evelyn Richardson (daughter)</i>		Address <i>Box 354 P.O. Bel Air, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral apoplexy</i> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 10</i> , 19 <i>56</i> , to <i>Oct 14</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Oct 14</i> , 19 <i>56</i> , and that death occurred at <i>4:55 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>Harford, Md.</i> <i>10-16-56</i>							
ACTUAL SIGNATURE <i>E. J. Simon</i>		M.D. <i>Harford, Md.</i>					
PHYSICIAN'S NAME (Type) <i>E. J. Simon</i>		<i>Harford, Md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 17, 1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Asbury</i>		22d. LOCATION (City, town, or county) (State) <i>Churchville, Harford, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard R. McComas & Son</i>		ADDRESS <i>Abingdon Md.</i>		24a. REC'D BY REGISTRAR DATE <i>Oct. 19-56</i>		24b. REGISTRAR'S SIGNATURE <i>A. L. Lewis m.d.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 182

10377

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pylesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pylesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>William L. Smith</u> First Middle Last		4. DATE OF DEATH <u>October 8</u> Day Month Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>	
11. BIRTHPLACE (State or foreign country) <u>HARFORD CO, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES L SMITHSON</u>		14. MOTHER'S MAIDEN NAME <u>OLEVIA SMITHSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Richard Linthorn</u> Address <u>Fawn Lane RD, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-10-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL METH. CEM</u>	22d. LOCATION (City, town, or county) (State) <u>PYLESVILLE, HARFORD Co, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. Osburn</u> ADDRESS <u>Stewartstown Pa</u>		24a. REC'D BY REGISTRAR <u>Oct-10-56</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Priscilla Woodward</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

OCT 15 1956

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

10359

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Harford</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Harford</i>		LENGTH OF STAY (in this place) <i>1 day</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Kingsville</i>		<i>03x-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Harford Memorial</i>				STREET ADDRESS (If rural give location) <i>Rural</i>			
3. NAME OF DECEASED (Type or Print) <i>Harold Irving Spencer</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Oct. 5 1956</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Jan 23 1897</i>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Service Station</i>		9b. KIND OF BUSINESS OR INDUSTRY <i>Gasoline</i>		9. AGE last birthday <i>59</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. FATHER'S NAME <i>Irving Spencer</i>				10b. MOTHER'S MAIDEN NAME <i>Belle Crowell</i>			
11. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>Yes</i>				12. SOCIAL SECURITY NO. <i>105-01-9130</i>		13. INFORMANT'S ADDRESS <i>Mrs Grace Spencer (wife)</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				16. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <i>Coronary occlusion</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs.</i>			
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic Cardiovascular Disease</i>				<i>10 yrs.</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)				21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 1956, to Oct. 5, 1956, that I last saw the deceased alive on Oct. 5, 1956, and that death occurred at 4 M, from the causes and on the date stated above.							
SIGNATURE <i>William A. Tyson</i> M.D.				ADDRESS (Street, city, town, state) <i>Kingsville, Md.</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>Oct 9 1956</i>		NAME OF CEMETERY OR CREMATORY <i>N. Syracuse</i>	
24. REC'D BY REGISTRAR <i>OCT 10 1956</i>				REGISTRAR'S SIGNATURE <i>Dr. A. A. Lewis</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>W. H. Archer</i>	
				ADDRESS <i>Benson</i>		<i>md</i>	

CERTIFICATE OF DEATH

Exhibit 10

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. TIME OF DEATH

6. CAUSE OF DEATH

7. PLACE OF DEATH

BUREAU V. S.

OCT 10 1956

RECEIVED

NOTATION

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during the last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland. It is to be filed with the local health officer and a copy sent to the State Department of Health. It is to be kept for a period of ten years.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10378

CERTIFICATE OF DEATH

10366

Reg. Dist. No.

182

1. PLACE OF DEATH a. COUNTY <u>Baltimore Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Miss Catherine Stempel</u>				4. DATE OF DEATH Month <u>October</u> Day <u>20th</u> Year <u>1956</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 13, 1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Theodore Julius Stempel</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Kantman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Anna Stempel, Fallston, Maryland</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>CORONARY OCCLUSION</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chr. SPONDYLITIS</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 1951</u> , 19____, to <u>Oct. 20, 1956</u> , that I last saw the deceased alive on <u>Oct. 20</u> , 19 <u>56</u> , and that death occurred at <u>3:20 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D.				ADDRESS (Street, city or town, state) <u>Forest Hill, Md.</u> DATE SIGNED <u>Oct. 21, 1956</u>			
PHYSICIAN'S NAME (Type) <u>WILLARD P. HUDSON, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/23/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leondard P. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>				24a. REC'D BY REGISTRAR DATE <u>Oct 23 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Priscilla Lowndes</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Faint text]		2. SEX [Faint text]		3. AGE [Faint text]		4. DATE OF BIRTH [Faint text]	
5. PLACE OF BIRTH [Faint text]		6. OCCUPATION [Faint text]		7. CAUSE OF DEATH [Faint text]		8. MANNER OF DEATH [Faint text]	
9. SIGNATURE OF PHYSICIAN [Faint text]		10. SIGNATURE OF REGISTRAR [Faint text]		11. SIGNATURE OF WITNESS [Faint text]		12. SIGNATURE OF DECEASED [Faint text]	
13. DATE OF DEATH [Faint text]		14. TIME OF DEATH [Faint text]		15. PLACE OF DEATH [Faint text]		16. OTHER INFORMATION [Faint text]	

BUREAU V. 2

OCT 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11405

Reg. Dist. No. 185-

10360

1. PLACE OF DEATH a. COUNTY Harford County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE New York b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace,		c. LENGTH OF STAY IN 1b 2 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital				d. STREET ADDRESS 2155 Grand Avenue			
3. NAME OF DECEASED (Type or print) First Jean Middle Tannenbaum Last Tannenbaum				4. DATE OF DEATH Month October Day 28 Year 1956			
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) 57 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Poland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jacob Rynland			14. MOTHER'S MAIDEN NAME Anna Weiss				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Hirsh & Sons Bronx, N.Y.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 816X Fracture Skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto Accident - Auto - Auto type					
20c. TIME OF INJURY Month, Day, Year Hour 6:30 10-28 1956 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. Route 40			
20f. (City or town) Aberdeen, Harford		(County) Maryland		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Noturol <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Gerald C. Palmer		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 10-28-56 Bel Air, Maryland			
EXAMINER'S NAME (Type) Gerald C. Palmer		22a. BURIAL, CREMATION, REMOVAL (Specify) Removal					
22b. DATE THEREOF 10/29/56		22c. NAME OF CEMETERY OR CREMATORY Montifiore		22d. LOCATION (City, town, or county) (State) Springfield, L.I. N.Y.			
23. FUNERAL DIRECTOR'S SIGNATURE John G. Harving		ADDRESS Aberdeen, Md.		24a. REC'D BY REGISTRAR DATE 11-29-56			
24b. REGISTRAR'S SIGNATURE A. L. Lewis m d l							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10580

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John W. Smith		45		Male		White		11/20/56		Home	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Previous Illnesses	
Heart Disease		Natural		Teacher		High School		Married		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

NOV 30 1956

RECEIVED

Charles E. Palmer

10361

CERTIFICATE OF DEATH

Reg. Dist. No.

181

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>31 Aberdeen</i>		c. LENGTH OF STAY IN 1b <i>about 50 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		<i>31</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>606 Dorsey Ave.</i>				d. STREET ADDRESS <i>606 Dorsey Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Frances</i> Middle <i>Taylor</i> Last <i>Taylor</i>				4. DATE OF DEATH Month <i>10</i> - Day <i>25</i> Year <i>1956</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-15-1881</i>	9. AGE (In years last birthday) <i>75</i> yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto. County, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Joshua Brown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mr. John Taylor, Aberdeen, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>581.0</i> DUE TO <i>Insanition</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cirrhosis of Liver</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i> <i>9 mo</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>(1950)</i> 19 _____, to <i>10-25-</i> 19 <i>56</i> , that I last saw the deceased alive on <i>10-24-</i> 19 <i>56</i> , and that death occurred at <i>11:50 A</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>8 Lam St. Aberdeen, Md.</i> DATE SIGNED _____							
ACTUAL SIGNATURE <i>Peter P. Redman</i>				PHYSICIAN'S NAME (Type) <i>Peter P. Redman</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-29-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Union Methodist Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Aberdeen, Harford Co - Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Otelia J. Bullock - House of Grace, Md.</i>				ADDRESS <i>556 Lavin St.</i>		24a. REC'D BY REGISTRAR DATE <i>Oct 27-56</i>	
				24b. REGISTRAR'S SIGNATURE <i>Nellie R. Perry</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CORONER		16. SIGNATURE OF JURY		17. SIGNATURE OF JUDGE		18. SIGNATURE OF CLERK		19. SIGNATURE OF SHERIFF		20. SIGNATURE OF DEPUTY SHERIFF		21. SIGNATURE OF CONSTABLE		22. SIGNATURE OF JAILER		23. SIGNATURE OF PRISONER		24. SIGNATURE OF GUARD		25. SIGNATURE OF WARDEN		26. SIGNATURE OF CHIEF OF POLICE		27. SIGNATURE OF DEPUTY CHIEF OF POLICE		28. SIGNATURE OF SQUAD LEADER		29. SIGNATURE OF OFFICER		30. SIGNATURE OF SERGEANT		31. SIGNATURE OF DETECTIVE		32. SIGNATURE OF PATROLMAN		33. SIGNATURE OF TRAFFIC OFFICER		34. SIGNATURE OF INVESTIGATOR		35. SIGNATURE OF FORENSIC EXAMINER		36. SIGNATURE OF MEDICAL EXAMINER		37. SIGNATURE OF PATHOLOGIST		38. SIGNATURE OF ANATOMIST		39. SIGNATURE OF HISTOLOGIST		40. SIGNATURE OF BACTERIOLOGIST		41. SIGNATURE OF VIROLOGIST		42. SIGNATURE OF PARASITOLOGIST		43. SIGNATURE OF IMMUNOLOGIST		44. SIGNATURE OF EPIDEMIOLOGIST		45. SIGNATURE OF PUBLIC HEALTH OFFICER		46. SIGNATURE OF HEALTH INSPECTOR		47. SIGNATURE OF SANITARIAN		48. SIGNATURE OF NURSE		49. SIGNATURE OF DENTIST		50. SIGNATURE OF VETERINARIAN		51. SIGNATURE OF PHARMACEUTICIAN		52. SIGNATURE OF OPTICIAN		53. SIGNATURE OF PODIATRIST		54. SIGNATURE OF CHIROPRACTOR		55. SIGNATURE OF NUTRITIONIST		56. SIGNATURE OF DIETITIAN		57. SIGNATURE OF PHYSIOLOGIST		58. SIGNATURE OF PSYCHOLOGIST		59. SIGNATURE OF PSYCHIATRIST		60. SIGNATURE OF PSYCHOLOGICAL NURSE		61. SIGNATURE OF SOCIAL WORKER		62. SIGNATURE OF COUNSELOR		63. SIGNATURE OF RECREATION THERAPIST		64. SIGNATURE OF ART THERAPIST		65. SIGNATURE OF MUSIC THERAPIST		66. SIGNATURE OF DANCE THERAPIST		67. SIGNATURE OF OCCUPATIONAL THERAPIST		68. SIGNATURE OF SPEECH THERAPIST		69. SIGNATURE OF AUDIOLOGIST		70. SIGNATURE OF OTOLARYNGOLOGIST		71. SIGNATURE OF OPHTHALMOLOGIST		72. SIGNATURE OF ORTHODONTIST		73. SIGNATURE OF ORTHOPEDIC SURGEON		74. SIGNATURE OF PLASTIC SURGEON		75. SIGNATURE OF RADIOLOGIST		76. SIGNATURE OF SURGEON		77. SIGNATURE OF UROLOGIST		78. SIGNATURE OF GYN/OB/GYN		79. SIGNATURE OF PEDIATRICIAN		80. SIGNATURE OF NEUROLOGIST		81. SIGNATURE OF NEURORADIOLOGIST		82. SIGNATURE OF NEUROPATHOLOGIST		83. SIGNATURE OF NEUROPSYCHIATRIST		84. SIGNATURE OF NEUROPSYCHOLOGIST		85. SIGNATURE OF NEUROSCIENTIST		86. SIGNATURE OF NEUROANATOMIST		87. SIGNATURE OF NEUROPHYSIOLOGIST		88. SIGNATURE OF NEUROIMMUNOLOGIST		89. SIGNATURE OF NEUROGENETICIST		90. SIGNATURE OF NEUROPHARMACOLOGIST		91. SIGNATURE OF NEUROTOXICOLOGIST		92. SIGNATURE OF NEUROETHOLOGIST		93. SIGNATURE OF NEUROEVOLUTIONARIST		94. SIGNATURE OF NEUROHISTOLOGIST		95. SIGNATURE OF NEUROIMMUNOLOGIST		96. SIGNATURE OF NEUROINTEGRATIONIST		97. SIGNATURE OF NEUROINVESTIGATIONIST		98. SIGNATURE OF NEUROINTEGRATIONIST		99. SIGNATURE OF NEUROINTEGRATIONIST		100. SIGNATURE OF NEUROINTEGRATIONIST	
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BUREAU V. S.

OCT 29 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10368

10362

CERTIFICATE OF DEATH

Reg. Dist. No. 186

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		STATE Maryland		COUNTY Harford			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN R#3, Bel Air, Md.		LENGTH OF STAY (in this place) 10 yrs		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural, Bel Air, Md.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Harford Memorial Hospital				STREET ADDRESS (If rural give location) Emmorton Village			
3. NAME OF DECEASED (First) (Middle) (Last) NORA CAROLINE WEAVER				4. DATE OF DEATH (Month) (Day) (Year) October 24 1956			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Wid.	8. DATE OF BIRTH April 28, 1871	9. AGE last birthday 85 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home maker		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) ash Co, M. C. 12 S. A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Hittington				14. MOTHER'S MAIDEN NAME America Eller			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S ADDRESS Mr. Floyd Weaver			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
443X IMMEDIATE CAUSE (A) Hemorrhage, due to rupture of esophageal varices.				INTERVAL BETWEEN ONSET AND DEATH 10 hrs			
ANTECEDENT CAUSE(S) DUE TO Vascular hypertension							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Chr. hypertensive cardio-vascular disease				10 yrs			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) Chr. spondylitis; osteoporosis							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. M. Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-29-42 , 19....., to 10-24-56 , 19....., that I last saw the deceased alive on 10-24-56 , 19....., and that death occurred at 3:30 A.M. from the causes and on the date stated above.							
SIGNATURE Willard P. Hudson				ADDRESS (Street, city, town, state) Forest Hill, Md.		DATE SIGNED 10-25-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 26, 1956		NAME OF CEMETERY OR CREMATORY Harmon Cem		LOCATION (City, town, or county) (State) Harford Co Md	
24. REC'D BY REGISTRAR Oct 27, 1956		REGISTRAR'S SIGNATURE A. L. Lewis		25. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey		ADDRESS Harlington, Md.	

• **1995** – 1996

226

BUREAU

RECEIVED
OCT 29

BUREAU V. S.

OCT 29 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10369

10379

CERTIFICATE OF DEATH

Reg. Dist. No.

182

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WHITEFORD				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WHITEFORD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM TURNER WHITEFORD				4. DATE OF DEATH Month Day Year 10-20-1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-4-1884	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
11. BIRTHPLACE (State or foreign country) HARFORD Co., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HUGH C. WHITEFORD		14. MOTHER'S MAIDEN NAME PHEBE FLAHERTY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. —		17. INFORMANT John C. Whiteford Whiteford Ind. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Tumor 237x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 yr.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March , 1955, to Oct. , 1956, that I last saw the deceased alive on Oct. 17 , 1956, and that death occurred at 9:40 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles A. Neff M.D.				ADDRESS (Street, city or town, state) STREET MD. DATE SIGNED Oct. 20, 1956			
PHYSICIAN'S NAME (Type) Charles A. Neff M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-23-1956		22c. NAME OF CEMETERY OR CREMATORY FAWN GROVE METH.		22d. LOCATION (City, town, or county) (State) FAWN GROVE, YORK Co., PA.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Howard Hot ADDRESS 1100 York St. York, Pa.				24a. REC'D BY REGISTRAR DATE 10-23-56		24b. REGISTRAR'S SIGNATURE Priscilla Lowwood	

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text: ...]</p>		<p>2. SEX [Faint text: ...]</p>	
<p>3. AGE [Faint text: ...]</p>		<p>4. DATE OF BIRTH [Faint text: ...]</p>	
<p>5. PLACE OF BIRTH [Faint text: ...]</p>		<p>6. OCCUPATION [Faint text: ...]</p>	
<p>7. MARITAL STATUS [Faint text: ...]</p>		<p>8. CAUSE OF DEATH [Faint text: ...]</p>	
<p>9. MEDICAL HISTORY [Faint text: ...]</p>		<p>10. DATE OF DEATH [Faint text: ...]</p>	
<p>11. PLACE OF DEATH [Faint text: ...]</p>		<p>12. SIGNATURE OF DECEASED [Faint text: ...]</p>	
<p>13. SIGNATURE OF WITNESS [Faint text: ...]</p>		<p>14. SIGNATURE OF PHYSICIAN [Faint text: ...]</p>	
<p>15. SIGNATURE OF REGISTRAR [Faint text: ...]</p>		<p>16. SIGNATURE OF CLERK [Faint text: ...]</p>	

BUREAU V. B.

OCT 25 1956

RECEIVED